

**MEDICAL BOARD OF CALIFORNIA**

LICENSING PROGRAM
 1426 Howe Avenue, Suite 54
 Sacramento, CA 95825-3236
 (916) 263-2382 FAX (916) 263-2487
www.medbd.ca.gov

**OFFICIAL BREAKDOWN OF UNDERGRADUATE CLINICAL CLERKSHIPS**

(The completion of this form is required only of international medical school graduates.

Please complete this form in the English language.)

Name of Applicant (type or print FULL name):	U.S Social Security Number: ____ / ____ / ____
	Date of Birth-MM/DD/YYYY:

Only undergraduate clerkships in which the applicant participated in **DIRECT, HANDS-ON DIAGNOSIS OR TREATMENT OF PATIENTS IN A CLINICAL SETTING** should be reported on this form. Any clinical clerkships completed that do not meet the above criteria should **NOT** be reported on this form as they will **NOT** satisfy California's clinical training requirements.

UNDERGRADUATE CLINICAL CLERKSHIPS

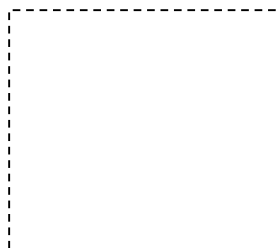
(Please list **ALL** clinical training completed prior to issuance of your medical degree in the area below and on the reverse of this form. List training in date/chronological order, commencing with the first clinical year of training.)

CLINICAL SUBJECT AREA	FACILITY NAME AND ADDRESS	DATES OF ATTENDANCE FROM -TO (Month/Day/Year)	WEEKS OR WEEKLY HOURS OF CREDIT

ATTENTION DEANS OR REGISTRARS: THE PERSON WHO SIGNS THIS FORM MAY NOT BE RELATED TO THE APPLICANT BY BLOOD, MARRIAGE, OR ADOPTION.

Only the Dean or Registrar may sign this form. If that signature authority is being delegated to another person, evidence of that delegation must be attached to this form (may be a photocopy). Such delegation must be on official letterhead and must be dated within the last 12 months.

MEDICAL SCHOOL SEAL



I, _____
 FULL NAME of Dean or Registrar (Please TYPE OR PRINT)

declare under penalty of perjury, that I am/was the Dean or Registrar for the student named above and that I have carefully read this form and that the statements made herein are strictly true in every respect.

 Signature of Dean or Registrar

 Date

L5A

OFFICIAL BREAKDOWN OF UNDERGRADUATE CLINICAL CLERKSHIPS

(Continued from the front of this form. If additional space is needed, you may photocopy this side of the form; however, original signatures and seals (below) will be required on all photocopies submitted.)

Name of Applicant (type or print FULL name):

U.S. Social Security Number:

____ / ____ / ____

Date of Birth-MM/DD/YYYY:

UNDERGRADUATE CLINICAL CLERKSHIPS

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